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When places come first: Suffering, archetypal space and the problematic production of global health

Introduction

In their recent treatise, the authors of *Reimagining Global Health* note that global health and its experiences are ‘rooted in time and place’ (Farmer et al., 2013, 11). As a geographer, what strikes me is that despite tantalisingly foregrounding the importance of place, Farmer and his colleagues never once return to any explicit consideration of the spatial constitution of global health in the 500-plus pages of their book. Yet, while I might greet this omission with frustration, it is unsurprising given biomedicine’s continued dominance of the global health field (Martin et al., 2015). Partly as a response to this disciplinary domination, critical social science engagements with global health have proliferated (see Herrick, 2016a for a review). However, for a ‘mix of scholarship, research and practice’ that claims to be ‘highly interdisciplinary and multidisciplinary’ (Koplan et al., 2009, 1993); global health seems instead to be characterised by distinct disciplinary siloes and territoriality, the *consequences* of which have rarely been examined. Within social science, medical anthropologists and political scientists have most successfully and ‘heartily adopted’ global health as ‘one of their fields of research and passwords for a larger audience’ (Fassin, 2012b, 96), arguably leaving allied disciplines trailing. But, as global health slowly gains traction within geography (see Herrick & Reubi, 2017 ; Taylor, 2017 ; 2016 ; Reid-Henry, 2016 ; Sparke, 2016 ; Mitchell & Sparke, 2015 ; Brown, 2014 ; Brown et al., 2012 for examples of some of the most recent contributions to the field), it is crucial to be cognisant of the extent to which this “obscure object” (Fassin, 2012a) of analysis has been constructed by particular disciplinary tropes and traits. Of these, arguably one of the most powerful has been the medical anthropological commitment to the ‘suffering subject’. Importantly and as this paper will explore, this example

offers up a crucial point of reflection (and indeed, caution) for health geographers who have recently been challenged over ‘losing sight of those who are truly in need and have the least resources to effect change to their health and their lives’ (Rosenberg, 2016, 8) under contexts of mounting inequality (Dorling, 2013).

Here then - and in contrast with previous geographical engagements with global health, which have tended to be relatively introspective in disciplinary terms (Brown & Moon, 2012 ; Herrick, 2014b) - I will advance a geographical critique of one of critical medical anthropology’s main claims to exceptionality in the global health field: the argument that *people who suffer* must ‘come first’ in the drive to document and ameliorate their ‘imperilled lives’ (Biehl & Petryna, 2013, 2). While health geography has been far more concerned with using ‘place’ as an explanatory frame for the genesis or experience of health/ illness (Gatrell & Elliott, 2014 ; Dunn & Cummins, 2007 ; Cummins et al., 2007 ; Gesler & Kearns, 2005), the constitution and condition of its human subjects has been far less central to its sub-disciplinary self-identity. This is in stark contrast to medical anthropology’s call to ‘bear witness’ to suffering (Butt, 2002 ; Robbins, 2013 ; Ticktin, 2014) and may well reflect the extent to which ‘in contrast with most social scientists from most other fields, medical anthropologists consider themselves both being in the position and having the obligation to change the world’ (Fassin, 2012, 114). However, a dearth of critical reflection on the nature and (most importantly) the *spatial* consequences of this defining anthropological characteristic is overdue given recent geographical interventions on closely-related concepts such as wounding (Philo, 2005), precarity (Waite, 2009), trauma (Pratt et al., 2015) and ‘less-than-human geographies’ (Philo, 2016). As a consequence, here I aim to drive geographies of global health in a new direction by examining how medical anthropology’s commitment to suffering and its relative dominance of the field have combined to *actively produce* and *render global health visible* by and through certain archetypal spaces of suffering, a process that is not without consequence.

Indeed, with global health such an elusive concept (MacPhail, 2014), it is often only through these archetypal spaces that we come to “know” what it is or might be (see Brada, 2011 ; 2016). Thus the largely-biomedical ‘enclaves’ (Nguyen & Peschard, 2003) of hospitals and clinics of the global south - and most notably, Africa (Geissler, 2013 ; Horton, 2016 ; Tilley, 2011) - have become global health’s most visible face, sites of investment and knowledge creation.

This critique will, in turn, advance two key arguments that hold the potential to carve out new directions in geographies of global health. First, that the search for suffering in its purest, most visceral forms inevitably leads researchers to certain spaces in which suffering is embodied, interventions are made to ameliorate it or sometimes worsen it. More often than not, these spaces are biomedical and consequently serve to entrench the very biomedical frame that critical social scientists so often decry (Biehl & Petryna, 2014). And, second, when our conceptualisation of suffering extends beyond the individual as vulnerable *victim* to think through the contexts in which *victimhood maybe more problematically or ambiguously configured* (i.e. in relation to pleasure-seeking or consumption risks for noncommunicable disease), then we become drawn to an array of different spaces of health production, erosion and negotiation where suffering is experienced and produced in more ambiguous ways (Janes & Corbett, 2009 ; Obrist et al., 2003). Advancing this argument not only offers up geographers an important and novel point of critical interjection within the global health realm, within which their voices have remained relatively peripheral (Herrick & Reubi, 2017), but in so doing also draws attention to the manifold ‘other’ places in which health comes to matter especially in relation to the genesis of non-communicable diseases (NCDs). Indeed, with the advent of the Sustainable Development Goals (SDGs) and the culmination of significant lobbying efforts, this is a crucial emergent agenda within global health which looks set to take

research, action and funding in new directions (Clark, 2013) and within which geographers are well positioned to play important roles.

To explore these ideas, I will first critically reflect on the emergence and contours of anthropology's "suffering slot" and its relationship to (and significance for) the field of global health. Second, I contextualise this genre of research and writing with reference to debates in Geography and Science and Technology Studies (STS) on the spatial constitution of scientific knowledge (Naylor, 2005) to work through the argument that anthropological attention to suffering has served to produce a number of "truth spots" (Gieryn, 2002) or places which, by their very nature and existence, authenticate the veracity of scientific knowledge claims. These are worthy of geographer's attention as they not only function as archetypal (biomedical) spaces in the communication, circulation and perpetuation of a particular vision of what global health is and should do, but they are also then divorced from the major socio-spatial drivers of the global burden of disease. As a result and as I argue, a plethora of "ignorance spots" (Frickel & Kinchy, 2015) – places that are deeply salient to health outcomes but outside the research purview - now scatter the landscape of medical anthropology and global health research. These "ignorance spots" are then productive sites of possibility for future geographical engagement with global health. To develop this contention, in the final part of this paper I will draw on recent anthropological and geographical work on obesity in the global south and my own research on alcohol consumption in Southern Africa to argue that a commitment to reducing the multi-dimensional suffering caused by complex disease syndemics (Singer & Clair, 2003 ; Singer et al., 2012) also requires a commitment to the exposition of a far greater range of global health spaces than has thus far been the case: homes; restaurants; bars; supermarkets; malls; and schools. Crucially, these are the very spaces in which suffering may be ambiguously figured and set in direct opposition to the immediate attractions of pleasure through the short-termism of "risky" lifestyle behaviours. In so doing, this intervention aims to advance an

important new geographical research agenda on the contemporary constitution of (global) health subjectivities in the context of NCDs, moving beyond medical anthropology's concern with suffering and victimhood to think through the nexus where suffering and pleasure-seeking collide in ways that can be at once purposeful and inadvertent and, as a result, always political.

Medical anthropology and the suffering slot

The “crisis” narrative that underpins so much of global health (McInnes, 2016) cannot be dissociated from the ‘profoundly self-reflective moment’ (Mascia-Lees et al., 1989, 7) that hit anthropology in the 1980s as the discipline’s very objects of analysis started to become problematic and be problematised (Robbins, 2013). As concern coalesced around the postmodern and postcolonial questions of power, authenticity, representation and construction of the discipline’s exotic “savage slot” (Trouillot, 1991); a critical moment had arrived where the ‘ethnographic Other [was] no longer available and pliant, awaiting anthropological representation, but [had] acquired a voice of his/her own’ (Singer, 1993, 15). Suddenly the search was on for new ethnographic subjects that might not only meet the aspirations of a truly valuable and meaningfully applied anthropology that fulfilled its ‘traditional moral imperative’ (Mascia-Lees et al., 1989, 9), but that also enabled researchers to address concurrent concerns that explanation should become as important to the discipline as thick description (Wolf, 1990). As Robbins argues, ‘from the early 1990s onward... it has been the suffering subject who has come to occupy [the Other’s] spot’ (2013, 447). As a result and in stark contrast to the far more diffuse range of subjectivities that interest medical geographers, ‘the subject living in pain, in poverty, or under conditions of violence or oppression now very often stands at the centre of anthropological work’ (*Ibid*). For many medical anthropologists, but mainly for a particular subset within critical medical anthropology, the moral duty to document this subject stems

from the belief that ‘suffering as the paramount reality of daily existence’ (Farmer & Kleinman, 1989, 138) has been rendered invisible in and by a ‘culture of inequality’ (Nguyen & Peschard, 2003). For this ‘troubled sub-discipline’ (Scheper-Hughes, 1990, 62), the anthropological turn to suffering became a unique claim to authenticity and moral worth, unmatched by other social scientific engagements with health and, crucially, rarely subjected to critical reflection (Robbins, 2013 ; Ortnner, 2016).

It is important to remember that with the discovery of AIDS in the 1980s, medical anthropology was confronted not only with new and exceptionally visceral forms of suffering close to home (Singer, 2012), but with the analytical conundrum that the disease was ‘not only affecting how we live and organise society but how...anthropology and the social sciences must analyse that reality’ (Herdt & Lindenbaum, 1992, 933). As an infectious ‘syndemic’ (Singer & Clair, 2003) that entwined the biological, social, cultural, ecological and political in newly punitive ways; HIV/AIDS demanded new analytical frameworks as much as it did biomedical innovations (Nguyen & Peschard, 2003). Importantly for anthropology, the disease fundamentally called into question its long-held frame of the “local” by drawing attention to the multi-scalar political economic and ecological interconnections of syndemics (Baer, 1997 ; Baer et al., 1986). Shifting the scalar focus necessarily meant paying attention to the same kinds of questions of power, control and de-medicalisation that, interestingly, also animated calls for a shift from the traditional medical geography of epidemiologically-guided locational analysis, to a more politically and theoretically-driven critical health geography (Kearns & Moon, 2002 ; Scheper-Hughes & Lock, 1986). However, just as with the turn to a ‘post-medical’ critical health geography (Kearns & Gesler, 1998 ; Kearns, 1993 ; Brown & Duncan, 2002 ; Parr, 2004), the ‘exact meaning of the term critical medical anthropology’ remains frustratingly opaque (Singer, 1989, 1200). This is not least because within it, ‘several different orientations are fellow travellers with a common passport’ (*ibid*). While the existence of a truly

‘common passport’ might be doubtful, if critical medical anthropologists are unified by anything at all it is arguably ‘the simple imperative to position [themselves] squarely on the side of human suffering’ (Scheper-Hughes, 1990, 73) in order to effect ‘an anthropology of affliction and not simply an anthropology of medicine’ (*ibid*). It is notable that this commitment to a particular subject, set of life conditions and political orientation has no corollary within health geography, even among those loosely united behind the ‘critical’ label.

In part therefore, the attention to suffering and affliction has emerged as a means to reconcile the perceived gulf between ‘the individualizing, meaning-centred discourse of the symbolic, hermeneutic, phenomenologic medical anthropologists’ and the ‘collectivised, de-personalised, mechanistic abstractions of the medical marxists’ (Scheper-Hughes, 1990, 62). For Scheper-Hughes and Lock (1986), attention to the subjective lived experiences of suffering offered up a corrective to the political economic tendency to ‘depersonalise’ its own subject matter in concentrating on the macro over the micro. Moreover, attention to suffering also provided an analytical and political route to “de-medicalisation” (i.e. undoing biomedical hegemony) by highlighting how suffering and sufferers might challenge the medical power structures that sustain their state and status (Singer, 1990, 185). Furthermore suffering also offered a framework to connect ‘personal illness meanings with larger political and social systems’ (Farmer & Kleinman, 1989, 152). In this trope - manifest as ‘structural violence’ in Farmer’s later work (1996 ; 2004 ; see also Farmer et al., 2006) - suffering is ‘an existential human dilemma’ (Kleinman, 1988, 26), compounded, augmented and magnified by multiple factors: stigma; racism; inequity; oppression; resource misuse (see also Biehl, 2016). This genre of ‘social justice scholarship’ (Butt, 2002) is uniquely suited to the global health field through its commitment to a politics of ‘humane responses to existential needs’ (Farmer & Kleinman, 1989, 148), operationalised through the methodology and ‘empirical lantern’ of ethnography (Biehl, 2016, 134) and a narrative style often characterised by the ‘sparse, if potent, use of

voices' (Butt, 2002, 6). Such concern with the universal, existential nature of suffering (Kleinman, 1988) also raises important questions about its implications for the discipline's 'core cultural values' (Farmer & Kleinman, 1989, 145) as well as questions of power (Farmer, 2005), autonomy, accountability, fate, control, rights and responsibilities (Das et al., 2001). This is in clear contrast to the more moderate political aspirations of recent critical geographical engagements with global health (Brown & Moon, 2012 ; Brown et al., 2012 ; Herrick, 2014c ; 2016a ; Sparke, 2009) and sociology's almost total silence in the field (Reubi et al., 2015).

The 'suffering slot' and its unique invocation of a plethora of damning nouns - violence, distress, crisis, catastrophe, trauma, endurance, abandonment, incoherence, fragility, harm, frailty, pain, malheur, precariousness, misery, affliction and vulnerability - vying to most graphically narrate the trials of suffering as 'the pan-human face of poverty' (Butt, 2002, 5) at the absolute margins (see for example Scheper-Hughes, 1993 ; Biehl, 2005 ; Bourgois & Schonberg, 2009 ; Fassin & Rechtman, 2009) has thus become a defining feature of critical medical anthropology. While there is a clear moral imperative to exposing these 'grim biographies' (Farmer, 1996, 272) and 'tortured narratives' (Scheper-Hughes, 2008, 27), the impulse has been roundly critiqued by some for situating 'whole communities within a discourse of victimization' (Panter-Brick, 2014, 439). It is also undoubtedly significant for future geographical research agendas that documenting and righting victimhood draws researchers towards the very medicalised sites that they so often disparage as obliterating human agency, ignoring human voices and for inadvertently perpetuating suffering by divorcing global health's programmatic intentions from the capacities of local contexts (Clark, 2014). Indeed and as Scheper-Hughes once noted, 'to date, much of the critical discourse in medical anthropology has been confined to the analysis of the cancer ward, the leprosy asylum, and the mental hospital as spaces of pain, exclusion, stigma and confinement' (1990, 70). It

would be wrong to suggest that nothing has changed in the past three decades – especially with the turn towards multi-sited ethnographies (Marcus, 1995) and the growing influence of STS (Janes & Corbett, 2009) - but critical medical anthropologies of global health remain notable for their continued and overwhelming focus on medical spaces as anthropological “truth spots” (Gieryn, 2002 ; 2006). This dominant spatial focus, in turn, has arguably obscured the role that other, non-medical, spaces may play in the genesis of illness and wellbeing in global health. As such and when combined with the frame of victimhood, this has also stymied deeper critical reflection on the multiple and often ambiguous routes by which suffering might emerge from conditions other than oppression, powerlessness and victimisation such as pleasure-seeking and behavioural acts of resistance.

The truth (and ignorance) spots of global health

The ‘geographical turn’ in STS (Naylor, 2005) has usefully explored how ‘scientific knowledge is a geographical phenomenon’ (Livingstone, 2010, 18 ; see also Shapin, 1998) in that it is not only produced *somewhere*, but that this location then often serves as a ‘modulator of scientific credibility’ (Gieryn, 2006, 27). While Latour and Woolgar’s classic text, *Laboratory Life* (1985), drew attention to the social production of scientific knowledge, subsequent work has drawn attention to the inherently geographical constitution of these socio-scientific processes (Finnegan, 2007). This is particularly relevant in the case of global health knowledge where place has ‘significance for science as a ratifier of authenticity and trust’ (Henke & Gieryn, 2008, 369) because ‘the place in which science is pursued is central to the veracity of the knowledge produced’ (Naylor, 2005, 6). While this interlinkage between knowledge and place often remains implicit rather than explicit, it is nevertheless something that cuts across both the biomedical and social sciences within the global health field. Here then the “hot zone” (Preston, 1994) of Africa has arguably emerged as the ultimate badge of

authenticity, not because suffering is necessarily greater here than other parts of the global south, but really because Africa has become the geographical *sine qua non* of so much global health research (Dedios & Anderson, 2014 ; Geissler, 2013 ; Prince & Marsland, 2013) even if geographers have been far too slow in dissecting the genesis and implications of this (Herrick and Reubi, 2017). Indeed, the ‘virtual invasion of Africa by international scholars’ (Janes & Corbett, 2009, 176), means that particular sites of African global health knowledge (re)production have become truth spots as much for anthropology as for biomedicine (Crane, 2011 ; 2013 ; Wendland, 2012 ; Brown, 2015 ; Herrick & Reades, 2016). In this context, the suffering slot has come to favour certain places that will most appropriately and powerfully act as ‘spatial devices’ (Street, 2014, 76) that render pernicious social relations, culture, bodies and knowledge visible, whether clinics, hospitals, laboratories or others. As such, these (overwhelmingly biomedical) places have become an ‘explicit factor’ in the ‘emplacement of legitimate knowledge’, rather than just a ‘tacit background’ (Gieryn, 2006, 28).

Of course within this particular body of global health research, the degree to which suffering provides the main justification or frame of reference varies significantly. Indeed, researchers such as Scheper-Hughes, Veena Das or João Biehl have been far more overt than others in their choice of sites of suffering. It must also be remembered that the broad corpus of global health research across the social sciences has concerned itself with an array of degraded environments and places linked to suffering from, for example, megacity slums (Moser, 2011 ; Oppong et al., 2015 ; Austin, 2015), to American inner cities (Meyers & Hunt, 2014) and vector habitats (Hinchliffe, 2015 ; Shaw et al., 2010). However, for those accounts where suffering has formed a primary epistemological lens, it has also produced very particular spatialities that are worth closer scrutiny. Biehl’s *Vita* (2005), for example, is the archetypal study of suffering and has been praised and critiqued in equal measure for ‘its finely tuned aesthetic of misery’

(Csordas, 2007) which deals with a drug and alcohol rehab centre that homes ‘life’s leftovers’ (Biehl, 2001, 131). The grim portrait that Biehl paints of this ‘zone of abandonment’ is one in which vita is ‘a microcosm’ not only of Brazil and its multiple systemic failings, but no less than ‘the poorest one-fifth of humanity’ (135). These populations of ‘ex-humans’ (141) are cast by Biehl as the ‘living dead’ left, in effect, to rot by society and failed by government. As a place, vita is not just a space of abandonment, but also one of addiction treatment, where biomedicine meets Christianity. While Biehl’s work is particular in its photo-documentation of extreme suffering – and perhaps matched only by Bourgois and Schonberg’s graphic work on drug-taking in *Righteous Dopefiend* (2009) – suffering is also inescapable in the notable number of hospital ethnographies that have carved out an important niche in the critical global health field. This influential body of research considers how hospitals are increasingly ‘situated’ in complex, relational and multi-scalar ways that reference local cultures and patients as much as they do the demands of global health funding streams, staffing, protocols, evidence gathering, partnerships, programmes and resourcing (Crane, 2013). They therefore start to uncover ‘how local phenomena trace the contours of a global political apparatus of health’ (Nguyen & Peschard, 2003, 461). Hospitals then become sites where ‘rather than argue about what [global health] is, we can look instead at how it is made’ (Brada, 2011, 292). This is because global health’s ‘obscurity’ (Fassin, 2012b) has, until now, largely been produced in and through hospitals, clinics and biomedical partnerships (Craddock, 2012 ; Petryna, 2009) given that these are primary loci of activity, funding and, as a result, critical social scientific attention. In their genesis of multiple forms of knowledge that comes to constitute the field of global health, hospitals also function as truth spots whose circulation, in turn, may entrench the biomedicity of global health (Shiffman, 2009 ; Kim et al., 2013).

Claire Wendland's work in Malawi and Johanna Crane's work in Uganda have both been significant in the global health field and explore how partnership working plays out in hospital space. For Crane (2013), the suffering produced by AIDS and experienced in Mbarara's Immune Wellness Clinic is both an opportunity and a necessity for the 'making' of global health science. In her field site, this comes together in the 'uncomfortable mix of preventable suffering and scientific productivity that characterise global health' (2013, 161). In this reading, suffering African patients become 'bodies of knowledge' for HIV/AIDS research projects funded by international grants (*ibid*) and undertaken across a variety of biomedical sites. The humanitarianism engendered by inequality and suffering then (ironically) become the pre-conditions making international 'global health programs both possible and popular' (Crane, 2013, 8 ; see also Livingston, 2014). Wendland's work highlights how suffering is not limited to the patients of Malawi's Queen Elizabeth Central Hospital, but also extends to the clinicians who care for them. As she writes, 'clinicians' working lives are in every respect shaped by the same structural violence that produces patients' suffering' (2010, 24). Their suffering may be marked by the persistent challenges posed by a lack of resources, obstructive bureaucracy, being unable to fulfil the expectations bestowed by medical training, personal poverty and the visceral nature of inequality brought home by the arrival of a steady stream of 'clinical tourists' from the medical schools of the global north. These factors converge to exacerbate the healthcare worker exodus from countries like Malawi, deepening the suffering of patients and providing further impetus and justification for those very same global health interventions that may then only worsen this human resources gap.

While Wendland and Crane explore the suffering experienced in and embodied by the hospital in a relational sense, Livingston's exceptional account of Gaborone's Princess Marina Hospital's (PMH) cancer ward offers up a 'compelling microcosm' of contemporary Southern African healthcare in the wake of HIV/AIDS. Livingston's work is important for the attention it

draws to the fundamental differences between the nature and experience of cancer between global north and south, where graphic, slow and distressing death marked by ‘florid, disfiguring growths’ (2012, 20) and often intolerable pain too often accompany a lack of the medical amenities needed to ‘smooth the rough edges of oncology’ (2012, 19). Livingston’s work could be critiqued for falling into the same trap that Ferguson (2010) identifies, of chronicling pain, disfigurement and suffering without offering up alternatives, of a vision of what “might work”. While this is not the stated aim of her outstanding book, this angle of critique highlights how the suffering slot’s moral compulsion to bear witness, give voice and undo silence (Farmer, 1996, 280) can actually produce new types of silences in the creation of partial forms of socio-spatial knowledge. Thus the hospital might also function as a conduit of exclusion in which the primacy of this archetypal space actually empowers the biomedical frame of global health (Clark, 2014). Indeed, by framing suffering in allopathic terms – through the language and empirical exposition of (the shortcomings of) treatment regimes, medication, technologies, intervention – the *genesis* and *experience* of disease by other means remains obscured and invisible to global health programmes (McCoy et al., 2009a ; 2009b).

With these examples in mind and to borrow a powerful term from Ash Amin’s recent critique of urban theory, I want to make a geographical observation: we currently have a remarkably ‘telescopic’ brand of global health, which tends to focus on specific (usually biomedical) sites and, in so doing, underplays ‘the myriad hidden connections and relational doings that hold together [global health] as an assemblage of many types of spatial formation’ (Amin, 2013, 483). A ‘telescopic’ perspective, with its concern with ‘discrete territories’ rather than the ‘relational topography’ advocated by Brown and Kelly (2014) tends to bring singular kinds of truth spots into focus, rather than encouraging reflection on how global health’s *broader* topography comes to discursively and materially make up the field. To counter this, Amin calls for a form of ‘concessionary urbanism’, which when applied to global health might juxtapose

truth and ignorance spots to produce a cosmopolitan array of archetypal spaces far more befitting of the multidimensional challenges faced in an era of sustainable development (Horton, 2014 ; Barkemeyer et al., 2014). This form of “concessionary” global health would need to explore how, while truth spots may help ‘legitimise particular scientific projects’ (Finnegan, 2007, 384), ignorance spots perpetuate the construction of global health from partial geographies or ‘spatial processes of geographical exclusion’ (Frickel & Kinchy, 2015, 176). Indeed, the genesis of this impressive and substantial body of ‘authentic’ empirical, ethnographic data on the situated experience of health and illness in *certain* sites of the global south may also serve to justify further investment in precisely those biomedical forms of global health many anthropologists so often critique. Thus while focussing in on biomedical spaces, practices and politics may shed crucial anthropological light on the limitations of the global health endeavour on the ground, it may also have the effect of further obscuring and distancing those “other” spaces of global health ignorance and “other” forms of suffering from view. It is to these other spaces and subjectivities and their potentiality for new geographical research agendas that I now turn.

The absent spaces of global health

Medical anthropology’s search for a ‘transcendental theory of suffering’ (Nguyen & Peschard, 2003, 454) and the research that it has engendered have had an under-explored, yet arguably critical consequence that are directly relevant to health geographers at a time when the worthiness of their subjects of research are under scrutiny. For, as Nguyen and Peschard suggest, ‘social suffering approaches also foreclose the possibility that what is at stake in anthropological considerations of the body may include issues other than affliction. Medical systems are not only preoccupied with pain and suffering, it is argued, but also are intimately

concerned with pleasures and passions’ (*Ibid*). While the descriptive intimacies of, for example, hospital ethnographies do not readily fit Farmer’s claim that there is a ‘deadly monotony’ (1996, 271) to stories of suffering, they are nevertheless inadvertently complicit in producing other presumed universalities. Indeed, Wendland herself acknowledges that critical scholars of health may lament ‘the devastating health effects of large-scale political economic processes [but fail] to examine seriously the small ways that people everywhere may resist the processes that exacerbate their suffering or commodify their succour’ (2010, 214). Resistance to the processes that exacerbate suffering are perhaps more obvious in a clinical setting - see for example Livingston’s exploration of cancer patients who refuse invasive treatment, eschewing the ephemerality of biomedical hope in favour of the inevitability of fate – but they also extend beyond hospitals into places that have long animated health geographers. Resistance can be rightly celebrated as the enactment of agency and individual empowerment, but it also represents a profound obstacle to health and the alleviation of suffering. This is most clearly the case when individuals turn to pleasure-seeking and risk-taking in the aspirational pursuit of lifestyle, often in defiance (or ignorance) of public health advice. So what happens when the pleasures of eating, drinking or inactivity lead to affliction and, moreover, what kinds of archetypal spaces might this more ambiguous mode of suffering invoke? Furthermore and crucially then, why should these be of concern to (and an important point of critical, conceptual interjection for) geographies of global health?

My own research on the urban governance of the behavioural risk factors for NCDs draws me to places where pleasure-seeking is not obliterated by suffering, but is instead both endemic and deeply problematic. It also draws me to places where the fact of *not* suffering is problematic. This is especially so in situations where the public health threat of the chronic health consequences of, for example, alcohol consumption, fail to materialise or are consistently ignored in favour of the short-term social attractions of drinking (Herrick, 2014a ;

Ragland & Ames, 1996). It is clear that alcohol and suffering are closely entwined, but it is also the case that drinking does not always result in suffering. Rather drinking is often used as a route to the alleviation of suffering – however temporary – through its ability to bring forth the kinds of pleasures usually only grudgingly acknowledged by public health advocates (O'Malley & Valverde, 2004). Indeed, public health's 'whole population' approach to alcohol risk reduction and scepticism of ethnography's supposed "problem deflation" tendencies (Room, 1984) through its focus on consumption practices as culture (rather than risk) has no doubt helped eviscerate pleasure from discourses of global health. This is despite the fact that the quest for pleasure through consumption both emerges from and contributes to somatic and psychological experiences of suffering. Importantly then, this more ambiguous suffering is arguably a very different type of 'stumbling block of unsatisfied vital needs' (Redfield, 2013, 37), but this should not mean that it is any less a worthy driver of the overriding humanitarian impulse of global health. Thus while attention to suffering is morally and pragmatically crucial, the constitution of anthropology's "suffering slot" actually and ironically ensures that global health's 'absent presences' such as NCDs continue to remain obscured as much in social as in spatial terms (Jönsson, 2014 ; Marrero et al., 2012 ; NCD Alliance, 2013).

The ambiguity of suffering in relation to NCDs, human health and wellbeing thus begs reflection on anthropological arguments that attention to the 'distal pathogenic effects' of structural inequities is needed to ensure that individuals are not held to blame for their poor health (Reubi et al., 2015, 5). The aetiology of NCDs can be far more complex than many of the infectious conditions that are the mainstay of global health. Vectors are no longer identifiable viruses, bacteria or organisms often existing outside immediate human control, but rather a pernicious and ephemeral amalgamation of individual and collective lifestyle choices, structural and environmental constraints and big business as 'problem inducer' (Babor, 2016 ; see also Kickbusch et al., 2016). It is therefore far harder to tease apart the relationship between

blame, victimhood and suffering when people may not be entirely “blameless” for some of the suffering engendered by NCDs. It is also far trickier to animate global health’s – admittedly “contingent” (Brada, 2016) - humanitarian zeal when individuals may be partially or inadvertently complicit in the genesis of their own suffering (Sridhar et al., 2011). In the context of global health research, we are still quite far from even tacit acknowledgment that suffering might not only be ambiguous, but can also be willingly self-inflicted through the short-term pleasure-seeking that comes from so many “unhealthy” behaviours (see Berlant, 2011). Such an assertion of behavioural autonomy still remains deeply controversial within a global health field so strongly allied to the humanitarian impulse, even as engagement with the idea has been more readily taken up within fields such as critical obesity studies (Colls & Evans, 2014 ; Monaghan et al., 2013). This is not to say that critical medical anthropologists have not concerned themselves with the embodiment and experience of NCDs (see for example Whyte, 2015 ; Bunkenborg, 2015 ; Mendenhall, 2015 ; Mendenhall et al., 2015 ; Mendenhall & Norris, 2015 ; Sanabria, 2016), but the discipline undeniably lags behind other social sciences including geography. This disciplinary disconnect only reinforces the need to dwell further on the complexities of suffering and its significance for the spatial contours of the global health endeavour in broad terms.

Indeed, as Wright has suggested in her exploration of the emotional geographies of development, ‘it is not just suffering that needs to be attended to. Indeed to focus unremittingly on pain and suffering risks re-inscribing dualisms (suffering = Third World, pleasure = First World) and reproducing the worthy subject of development as someone that (only) suffers’ (2012, 1118). We thus need to go beyond suffering in the context of an interdisciplinary global health to avoid falling into the trap of geographical essentialisms and spatial exclusion, but also to critically reflect on the question of “worthiness” in the context of health and development subjectivities. In her research in Guatemala, for example, Yates-Doerr (2015) explores how

the ‘metrification’ of obesity through clinics, prescription weight-loss pills, Body Mass Index (BMI) charts and nutritional prescriptions is at odds with women’s own narrations of food and health in the kitchen. Here the ‘culinary care’ of nourishing family and friends and marking social status was also a crucial element of the wellbeing derived from pleasure, regardless of BMI (see also Yates-Doerr, 2012). Yates-Doerr and Carney contend therefore that ‘kitchens, although they are not biomedical sites, are places in which women seek to produce and respond to very real forms of health’ (2015, 6). Thus, while ‘pleasure may be positioned as a danger to health in biomedical formulations of food/ nutrition, here pleasure is both a means to and expression of health’ (2015, 10), thus making it a “worthy” object of concern. For the obese women that they encountered in their ethnographic work, straddling the worlds of clinic and kitchen – worlds where health and pleasure mean such different things and require such contrasting behaviours – was confusing and perilous. To address these dissonances, they call ‘to expand the concept of “health” from clinics to kitchens, families and broader social worlds’ (2015, 14). In so doing, they also argue that the ‘anthropology of health may have little to do with medicine’ (*Ibid*) and that, as some geographers have already argued (see for example Fleuret & Atkinson, 2007), ‘there is an urgent need to reconceptualise health from other places’ (Yates-Doerr & Carney, 2015, 15).

While Yates-Doerr and Carney do not explicitly draw out the spatial dimensions of their broader argument, their unusual interjection upon the primacy of the suffering slot is crucial to marking out not only an important future point of synergy between critical medical anthropology and geography, but perhaps more importantly, a prospective niche for geographers of global health. Geographers have long argued that health and place are recursively entwined (Kearns, 1993). Thus, while Yates-Doerr and Carney’s assertion that a turn to the non-medical spaces where health is contested, produced and experienced signals theoretical novelty in medical anthropology, it actually chimes with a wealth of existing

research and writing in health geography (see for example Gesler & Kearns, 2005). Indeed, as geographer Mark Hunter's important book, *Love in the time of AIDS*, shows, susceptibility to HIV and the experiences of sero-positivity are not just made in and through biomedical spaces; but also through intimacy, or what he calls the 'materiality of everyday sex' (Hunter, 2010, 4). Here "health" may be linked to the medical, but also the mundanity of home, the bedroom and other loci of intimacy and acts of resistance. This not only chimes with Ian Whitmarsh's recent assertion that 'the cultural domains that anthropologists have traditionally examined... now fall under the purview of "health"' (2013a, 304 ; see also Obrist et al., 2003), but also the long-held geographical interest in 'therapeutic landscapes' (Gesler, 1992). The present challenge is thus to ensure that these 'cultural domains' are actually opened up to the global health gaze, an epistemological shift that geographers should be loudly advocating for. Indeed, just as practitioners now concede that 'the global health enterprise has not been as successful as it should at including non-medical skills in its activities' (Martin et al., 2015, 1), critical social science researchers across the disciplines must also be attuned to the non-medical *spaces* in which health is a quality that may be put at risk, lost, maintained, or enhanced' (Obrist et al., 2003, 270) and not merely experienced as suffering. This is even more so in a context when calls for 'multi-sectoral' health policy are being mainstreamed in order to effect the SDGs (see for example Corburn et al., 2014).

Thus while countries of the global north have become attuned (and often inured) to the kinds of health promotion, lifestyle and NCD prevention activities envisaged by the SDGs – alcohol units, nutritional guidelines, physical activity prescriptions, smoke-free legislation – many countries of the global south are only just starting to develop their own strategies. At the same time, the spaces that will undermine NCD prevention efforts through the perpetuation of "risky behaviours" – bars, nightclubs, supermarkets, fast food restaurants, fortified gated communities, privatised green space - have already mushroomed (Watson, 2014 ; Solomon,

2016). Running alongside this, the commercial palliatives to NCDs – gyms, Zumba classes, “sugar-free” options, weight-loss surgery – are already a firm fixture for the urban middle classes across the global south (Whyte, 2014 ; Baglar, 2013 ; Whitmarsh, 2013a), even as they remain absent from global health research priorities regardless of discipline. This is a huge oversight because residents of the global south do not just subsist with and suffer through what Susan Whyte (2014) has called ‘life conditions’, but rather increasingly have the same ‘lifestyle’ aspirations and rights as those in the global north. This has significant ramifications for how we engage with the spatialities of NCD risk just as much as how we think about suffering and, importantly global health “beyond humanitarianism” (Gostin, 2016). Yet, there are tentative signs that medical anthropology may edging closer to geography as Harris Solomon’s recent work (2016) on metabolisms of obesity and diabetes in Mumbai shows. This fascinating book, anchored in the anthropological commitment to the ethnographic method but nonetheless completely indebted to the multidisciplinary contributions that make up ‘critical obesity studies’, offers a rare exploration of how the urban and health interlock and unfold on the ground (see Herrick, 2015). Through his explorations of tropes such as ‘tenshun’ (ostensibly stress) and ‘metabolism’ that link bodies and environments (see also Marvin & Medd, 2006 ; Heynen et al., 2006 ; Gandy, 2004), he sheds light on the city spaces where diet, exercise, diabetes and exercise become as meaningful as they do problematic. These are then not just weight loss clinics or the operating theatres for bariatric surgery, but also the *vada pav* stalls selling unhealthy (but culturally potent) snacks and the aspirational and tempting spaces of consumption offered up by Mumbai’s continued urban development.

These sites and the people who navigate them are the neglected *spaces* and *subjects* of global health. In a ‘dystopia of lifestyle pandemics’ (Whitmarsh, 2013b, 309), such places become new archetypes for the management of the short term attractions of pleasure relative to estimations of the likelihood of future suffering (Berlant, 2011). As should thus be achingly

clear to health geographers, they are not a distracting frivolity from the real biomedical spaces of global health, but rather crucial and alternative archetypal spaces where suffering and pleasure collide in complex ways that are too often antithetical to good health. They are also intensely political spaces, where commercial exigencies, vested interests and public health aspirations crash into the individual freedom to consume (see for example Bell & Ristovski-Slijepcevic, 2015 ; Sanabria, 2016). These spaces thus represent an uneasy addition to the architecture of global health not just because of the financial entanglements between some of the ‘commercial vectors of disease’ and major global health players such as the Gates Foundation (Stuckler et al., 2011 ; McGoey, 2015), but also because they fundamentally destabilise the conceptual and moral foundations of the suffering slot. Yet, as I have argued, they must become global health’s new archetypal spaces if we are to realise ‘the promise suffering slot anthropology always at least implicitly makes: that there must be better ways to live than the ones it documents’ (2013, 458).

Conclusion: when places come first

If the ‘ultimate goal of anthropological work in and of global health is to reduce inequities and contribute to the development of sustainable and salutogenic sociocultural, political, and economic systems’ (Janes & Corbett, 2009, 169), then this paper offers up an important reason for health geographers considering *who* they should be researching to pause and reflect. Critical medical anthropology’s “suffering slot” has produced an impressive wealth of vital scholarship within the critical studies of global health field, thus far unmatched by any other social science. Yet even where this genre of work has acknowledged that human vulnerability and trauma can be matched by the ‘bio-evolutionarily derived, historically situated and culturally-elaborated capacity for resilience’ (Scheper-Hughes, 2008, 52), the lure of ‘everyday

resistance' has not yet been as strong as the compulsion 'to identify the forces conspiring to promote suffering' (Farmer, 1996, 280). Within the suffering frame then, life can often be reduced to a state where 'in the context of these besieged lives, existence itself – living and surviving to tell the tale – is more than enough to celebrate' (Scheper-Hughes, 2008, 52). Yet as I have explored, the example of behavioural risk factors for NCDs shows clearly how human lives celebrate more than just existence and survival. Indeed, when stories start and stop at suffering, the anthropological ability to 'criticis[e] the taken for granted' (Brada, 2011, 307) may be limited because, as I have argued, suffering so often leads researchers to the same biomedical sites that they also argue over-dominate global health. Moreover, in reinforcing biomedical spaces such as hospitals and clinics as archetypal spaces of global space – its "truth spots" – this canon of research may also be (in)advertently complicit in excluding the others spaces and disciplines that offer up great contributory potential to global health.

NCDs still lurk in the shadow of the contemporary global health enterprise: they opportunistically emerge in the wake of better HIV/AIDS treatment (Livingston, 2012), they are syndemic with the rising stresses of "modern" life across the global south (Mendenhall, 2015 ; Mendenhall et al., 2015), they proliferate in the care gaps left behind when global health projects co-opt health workers and services (Geissler, 2013), they attract insufficient attention and they raise difficult ethical questions around issues of blame, victimhood, responsibility and choice in relation to suffering (Herrick, 2016b). NCDs also emerge in the liminal spaces between pleasure and pain, where the aspiration of the former eclipses the long-wave potentiality of the latter (Whyte, 2014). Lifestyles and lifestyle diseases are painfully relevant to global health (Garrett, 2013) even if the dots between NCDs and the global south are so rarely connected in research, practice or funding (Reubi et al., 2015). As I have argued here, critical medical anthropology's drive to ensure that blame is re-routed from vulnerable individuals to the structural conditions driving suffering too often evades the uncomfortable

reality that sometimes people may be complicit in their own (poor) health, even if inadvertently. This is hardly surprising if we concede Das' point that, even in poor places, life is as much about suffering as it is 'the small pleasures of everyday life' (2015, 2). The thresholds where pleasure tips into suffering are therefore not only crucial to the unfolding trajectories of health, but also how we as geographers should think about global health and its emergent subjectivities in spatial terms.

As such, social justice scholarship is increasingly at odds with other strands of critical health research exploring how mundane, everyday lifestyle behaviours index values, attitudes and understandings of health (Evans et al., 2012 ; Andrews et al., 2012). In turn and as Whyte explores in the case of Uganda, these cement new archetypal spaces of global health - gyms, supermarkets, health food stores, bars – to the topography of global health. These spaces are very weak contenders for the suffering slot and ethnographic attention to them may even seem flippant when contrasted with valiant efforts to trace 'new dystopic epidemiologic narratives' of infectious and NCD co-morbidities that 'gain synergy around poverty' (Livingston, 2012, 34). Yet it is crucial to remember that the lived experience of this 'dystopian' reality also drives people to the doors of these other spaces as they medicate pain and poverty with alcohol and numb the uncertainty of illness with fast food. This provides an important counterpoint to the assertion that 'many illnesses that enter the clinic represent tragic experiences of the world' (Scheper-Hughes, 1990, 70) and open up the interdisciplinary possibility that health status might represent pleasure as much as tragedy. Indeed and as geographers have long argued, when the *places* that people inhabit and encounter come first it might be possible to bring forth a global health that is more representative of and sympathetic to the ambiguities between pleasure and suffering. Such a perspective might then just bring forth the broader topography of salutogenic spaces needed to explode global health's somewhat 'telescopic' geographical

imaginaries in favour of something far more elided, ‘concessionary’ (Amin, 2013) and, crucially, reflective of the dynamism of lifestyles in countries of the global south.

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